

Evaluating Medicaid's Options & Obligations After the Supreme Court's ACA Decision

*Washington Health Care Authority
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Overview of the Supreme Court Decision

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A divided Supreme Court ruled that:

- **The Affordable Care Act (ACA) requirement for individuals to have insurance or pay a tax penalty is constitutional.**
- **States can choose not to expand Medicaid to cover all state residents under 138% FPL, without risking federal funding for their entire Medicaid program.**

“The Affordable Care Act’s requirement that certain individuals pay a **financial penalty for not obtaining health insurance may reasonably be characterized as a tax.** Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness.”

– *Chief Justice Roberts in Majority Opinion*

“In this case, the financial ‘inducement’ Congress has chosen is **much more than ‘relatively mild encouragement’**—it is a gun to the head.”

– *Chief Justice Roberts in Majority Opinion*

The Decision's Implications for Medicaid

States May Opt Out of Medicaid Expansion



The Balance of ACA Medicaid Provisions Stand

- Simplification and Streamlining
- Children's Expansion
- Maintenance of Effort
- Drug Rebates in Medicaid Managed Care
- DSH Payment Reductions
- Delivery System Reform

Welcome Mat Effect Occurs Regardless of Expansion

Framework for Assessing Medicaid Expansion

Medicaid Expansion: Factors for State Evaluation

- 1 Cost of coverage for adults in new expansion group**
- 2 State savings from current Medicaid and state funded populations and programs and new state revenue**
- 3 Broader economic value of additional health care dollars to health care system and state economy**

1

Estimate Cost of Coverage for Newly Eligible Adults

- **Define:** Adults under age 65 with incomes below 138% FPL who are not eligible under an existing Medicaid category
- **Numbers:** Calculate number of uninsured adults in state who fall into this new adult group
- **Enrollment:** Project take-up rates; no means-tested program ever achieves 100% take-up
- **Cost of Coverage:** Multiply projected enrollment by PMPM cost
- **Federal/State Cost Breakdown:** Calculate state share of costs; enhanced federal fund cover 100% costs of “newly eligible” adults from 2014 through 2016, leveling off at 90% in 2020
- **National estimates of cost of “newly eligible” adults (2014-2019):**
 - Federal spending: \$427.2 billion
 - State spending: \$17.1 billion

2

Offset State Savings and New State Revenue

- **Current Medicaid Populations that Can Move to New Adult Group with Enhanced Federal Matching Dollars or to Exchange with Tax Credits**
 - Coverage through 1115 waivers
 - Breast and Cervical Cancer Treatment Program
 - SSI Presumptive
 - Other?
- **Current State-Funded Programs for Uninsured Individuals**
 - Uncompensated care pools
 - Public and private mental health/substance abuse programs and agencies
 - State high risk pools and other private market supports
 - Health care costs of prisoners
 - Other?
- **Current Locally-Funded Programs**
- **Additional Revenue From Provider/Insurer Assessments and Business Taxes**

3 Project Impact on State Economy

- **Reduced Numbers of Uninsured**
 - Improved access to care and reduced mortality
 - Reduces personal bankruptcy; medical debt is leading cause
 - Less cost-shifting by providers
 - Facilitates reform of health care delivery system
- **Increased Revenue for Providers**
 - Especially critical for hospitals to offset reductions in DSH and Medicare rates
- **Increased Employment in Health Care Sector**

Implications of Not Expanding Medicaid

Implications of Not Expanding Medicaid: Consumers

- Individuals eligible for Premium Tax Credits only if their income is above 100% of the FPL; no subsidies available for:
 - Childless adults with incomes below 100% of the FPL
 - Parents with incomes between 74% (MAGI-converted) and 100% of the FPL
- Patchwork of coverage continues
- Continuity of coverage and care compromised
 - Individuals will not experience seamless transitions between Medicaid and Premium Tax Credits in the Exchange
 - Churning becomes a bigger problem

Implications of Not Expanding Medicaid: Providers

- Hospitals will see reductions in federal DSH funding
 - Preliminary total Medicaid State DHS allotment in 2011 = \$11.3 billion
 - Reduction to total State Medicaid DSH allotments start in 2014:
 - 2014 - \$500 million
 - 2015 - \$600 million
 - 2016 - \$600 million
 - 2017 - \$1.8 billion
 - 2018 - \$5 billion
 - 2019 - \$5.6 billion
 - 2020 - \$4 billion
 - If Washington does not choose to expand Medicaid, hospitals will face both DSH cuts and continuing uncompensated care burden
- With expansion, hospitals in Washington will see uncompensated care cost reductions estimated to be between \$477 million and \$608 million

Implications of Not Expanding Medicaid: Employers

- Employers will have new coverage obligations with respect to individuals with incomes between 100% and 138% FPL
- Large employers (50+) will face a penalty if one or more of their full-time employees with incomes between 100% and 138% FPL obtain a premium tax credit through the Exchange
- Penalty assessed on a monthly basis and calculated based on the number of full-time employees and whether the employer offers affordable Minimum Essential Coverage

Implications of Not Expanding Medicaid: Exchange

- Complex administration of the interface between State Medicaid programs and Exchange
 - Higher volume of “hand-offs” from Exchange to the State Medicaid agency, as a result of very low-income people seeking full Medicaid determinations and/or authorization to “spend-down” to the State’s Medicaid eligibility level
- Instead of a uniform eligibility threshold for Medicaid at 138% of FPL, Medicaid programs and Exchanges will be determining eligibility against patchwork of existing state Medicaid categories of eligibility with variable income levels

Open Policy Questions



Question: Is the adult expansion an “all or nothing” choice? Will states be allowed to expand adult coverage to levels less than 138% and receive the enhanced match?

- **Answer:** Unclear

Question: Will states be able to opt in and out of the adult coverage option over time?

- **Answer:** Yes

Question: Must a state expand its Medicaid program by January 1, 2014? May a state phase in Medicaid coverage up to 138% FPL (or less) after January 1, 2014 and still receive the enhanced FMAP?

- **Answer:** Per the ACA, expansion to 138% of the FPL is effective January 1, 2014. No matter when a state begins expansion, the 100% matching rate ends in 2016.

Question: Do all other Medicaid provisions stand?

- **Answer:** Yes (see discussion that follows)

Balance of Medicaid-Related ACA Provisions Stand

Simplification and Streamlining

- *Simple, seamless system* to determine eligibility for Medicaid, CHIP and Premium Tax Credits (PTCs); integrated with Exchange
- *90/10 funding* for development of ACA-compliant Medicaid eligibility systems and 75% match for operations; spillover benefit for social services programs.
- *Standardized definition of income* (MAGI) to determine program eligibility for Medicaid/CHIP/PTCs.

Children's Expansion

- Increases *Medicaid eligibility to 138% FPL* from 100% FPL for children ages 6 to 18

Maintenance of Effort

- Requirement to *maintain current eligibility levels/procedures for Medicaid & CHIP* until 2014 for most adults and 2019 for children
 - Adult MOE ends when Secretary certifies Exchange operational in a state
 - State receives enhanced match for CHIP (23 percentage points) starting in 2015

Balance of Medicaid-Related ACA Provisions Stand

Drug Rebates in Medicaid Managed Care	<ul style="list-style-type: none">▪ Authorizes <i>states to access prescription drug rebates</i> for enrollees of Medicaid managed care plans
DSH Payment Reductions	<ul style="list-style-type: none">▪ Secretary to determine reduction methodology▪ ACA requires largest reduction to states with lowest percentage of uninsured; or, do not target to hospitals with high-Medicaid volume and high uncompensated care costs▪ ACA also requires smaller reductions to low-DSH states
Delivery System Reform	<ul style="list-style-type: none">▪ <i>Health home services</i> for chronically ill Medicaid patients funded 90% federally for 2 years▪ <i>Medicaid primary care payment increases</i> to parity with Medicare rates in 2013 and 2014, funded 100% federally▪ <i>Medicaid and Medicare innovation initiatives</i>, including Accountable Care Organizations and Dual Eligible Initiatives

Questions?

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